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ORIGINAL COMMUNICATIONS.

REPORT OF COMMITTEE ON DR. WM. PEPPER'S CASE OF EXTRA-UTERINE PREGNANCY.

ANATOMICAL DESCRIPTION.

AS the parts stand in position, the tumor is on right side. At upper portion of tumor is attached the omentum, having considerable fat in it.

The peritoneum everywhere is smooth; in front is the bladder, normal internally and externally. At lower portion of specimen is found about one inch of the vaginal canal; its mucous membrane is normal. Os uteri is patulous, transverse, admits tip of little finger. Later in the dissection, it was seen that mucous membrane of uterine cavity and of neck was normal. Length of body of uterus, 3½–4 inches; width, 1½ inches.

Left fallopian tube seems elongated; its fimbriated extremity normal. L. tube seems to join body higher on fundus uteri than usual. L. ovary of normal size; ovarian surface shows cicatrices and what are apparently Graafian vesicles. L. broad ligament apparently normal.

The tissues in Right broad ligament are thickened at its upper part and close to body of uterus. An incision was made on anterior surface of this ligament, and by careful study of outline of uterus it was found that uterine body was dragged, or rather rotated in its lateral plane towards right. On examining interior of uterine cavity, the opening of r. fallopian tube is seen to be much lower down than that of left side; the left one being at highest part of cavity.

Commencing at r. fimbriated extremity, which is normal, r. fallopian tube can be traced up to and upon the tumor (its under surface). Here an incision of sac of tumor has been made, previously to the specimen being handed to your committee for examination, in such manner as to cut r. tube. It is impossible to trace the tube into the thickened tissue at upper border of r. broad ligament between tumor and body of uterus.

The distance between point where r. tube cannot be farther traced and uterus is about two inches.

On surface of incision, made on anterior surface of r. broad ligament, as above mentioned, careful search was made for a r. fallopian tube, extending from tumor (the point where it is lost) to body of uterus; but there was nothing present that could be identified as such a structure. The tissues here, made up partly of sac of tumor, at its point of contact with upper margin of r. broad ligament, and partly of continuation of ligament to body of uterus, are so thickened and changed from normal conditions that the existence of a fallopian tube (undiscovered) in them is quite supposable.

On surface of this incision is found an arterial vessel (containing reddish clot, in recent condition); through it a probe was passed; towards uterus, probe reaches as far as body; in opposite direction, the vessel branches, and through one of largest branches probe makes its appearance on internal surface of sac of tumor in the midst of a raised portion of fibrous-looking tissue, to be described later.

On attempting to pass a fine probe through r. tube, it is found to reach nearly (within one-third inch) to sac of tumor; *i.e.*, nearly as far as tube can be traced. In the portion of sac of tumor to right of incision made in it previous to specimen coming into possession of your committee, is found what is considered to be a farther portion of r. fallopian tube, separated from outer part of tube by the cut: it is impossible to pass probe through it. It is clear that probe, passing along r. tube from fimbriated extremity inwards, does not tend to enter cavity of sac of tumor; the tube on its way to r. broad ligament passing rather under, or in front of wall of sac. It is also impossible to pass probe to any distance into r. fallopian tube from uterine cavity.

A probe passes along l. fallopian tube from fimbriated extremity to within half-inch of uterus, but cannot be made to enter its cavity; neither can probe be made to enter uterine orifice of l. tube.

R. ovary appears the same as left; the point of contact of tumor with r. broad ligament is inwards (*i.e.*, nearer uterus) from this ovary.

No section was made of either ovary.

The tumor is said to have rested on right anterior brim of pelvis; and it is evident, from condition of specimen, that it has not been making pressure on pelvic organs.

Its surface is everywhere smooth and shining, except at parts where omentum is attached.

The mass is irregularly rectangular, flattened at sides, especially at superior part; inferior part is rounded, convex in both directions; at posterior part the outline slopes upward and backward (cutting off posterior inferior angle of rectangular figure); the anterior surface is flatter, though slightly convex from side to side, smooth at inferior portion, and roughened at superior, especially in median line; the superior lateral portions are slightly rounded, and the width of this surface is less here than below. At superior anterior border, omentum is attached, and thence, also, along superior surface. Superior surface is narrower than inferior; in its median line is a low ridge, made up of more or less regularly placed small prominences (processes of vertebræ).

The posterior border terminates in an angular-shaped prominence, rounded at its end and slightly curved downward.

The prominences on surface of tumor—of which there are many—are in general placed symmetrically.

The sac of tumor has been opened, as above mentioned, by an incision along inferior surface,—its thickest and densest part. The sac has been peeled off over a considerable portion of tumor; its thickness, as far as examined, varies very considerably at different parts—from an excessive tenuity, rendering dissection impossible, to about one line in thickness, at line of incision.

On inner surface of sac, near point of contact of sac with upper border of r. broad ligament, is a raised portion of fibrous-looking tissue, above mentioned. Here it is that the only distinct vascular trunk is found, coming along broad ligament and branching in the fibrous-looking tissue. This tissue presents a radiating surface-appearance, thickest in middle (remains of placenta). This surface had been separated from tumor before our examination There is found no structure proceeding from it, or attached to it, that could be identified as umbilical cord. No trace of umbilical cord was found during later examination; its abdominal attachment being covered by the folded head and extremities. No attempt was made to remove these structures.

The line of incision of sac is found to correspond to sagittal suture of fœtal head; the suture is slightly overlapped by left parietal bone. The anterior surface of tumor is made up of occipital bone, neck and back as far as upper dorsal region; the shoulders and scapulæ are at superior anterior angles of rectangle. At this border, spine is bent at right angles, and dorsum, as far as sacrum and coccyx, forms superior surface of tumor. The posterior surface extends from point of coccyx to fœtal forehead; on this surface are arranged the lower extremities, which can be only partially traced.

On right side of frontal bone, parallel to coronal suture, is placed the right hand; wrist is at anterior inferior parietal angle; tips of fingers reach median line of frontal bone.

The left hand, partially closed, is placed on left parietal bone, in advance of its protuberance; left wrist is dislocated, the carpal ends of bones of forearm are projecting.

The arms are placed at sides of trunk; forearms of both sides are flexed at acute angle on arms, the left the most so. The bones of both superior extremities are to be well traced; those of right forearm are least distinct, however.

The right femur is placed obliquely on posterior surface, running obliquely downward and to right, from point of coccyx; its head and neck contribute, with coccyx, to making up the rounded termination of angular-shaped prominence at posterior end of superior surface. Right leg can be traced running across forehead, downward, forward and to left; the ankle resting to left side of anterior fontanelle; knee being close to right wrist; foot cannot be distinctly traced.

Behind and slightly above right leg, on posterior surface of tumor, and exactly in median line, is a prominence, evidently condyles of l. femur. Head of l. femur is apparently in articulation with pelvis.

MEASUREMENTS.

Bi-parietal, width 3⅛ inches.

Antero-posterior diameter of mass (greatest), 4⅝ inches.

Vertex to bend of spine in dorsal region, 4⅜ inches.

From dorsal bend to point of coccyx, 4⅝ inches.

Left humerus, length 2 inches.

Right humerus, length 2¼ inches.

Left forearm, length 1¾ inches.

Right femur, length 2½ inches.

On inner side of tumor (*i.e.*, left side of fœtus), at superior anterior angle is a prominence not present on opposite side. This prominence commences ¾ inch from median line of dorsum, extending downward and slightly backward, reaching nearly to middle of shaft of l. humerus; in front of prominence is l. scapula and shoulder-joint. Prominence measures 1½ inches long, perhaps 1 inch broad; surface-projection low and flattened.

The interest which this prominence possesses was first noticed by Dr. Nancrede whilst making the drawing. The drying of its surface made its nature apparent. It is another fœtus.

At its upper and back part are seen the spinous processes, etc., of its vertebræ; running from thence, forward and downward, are ribs. The second fœtus's head, therefore, is placed behind shaft of l. humerus. The head has been much flattened, its bones separated and displaced. The sacrum is directed upward and forward, reaching nearly to inferior angle of scapula, near the point where vertebral column of large fœtus makes sharp bend in dorsal region.

Vertebræ and ribs are most distinctly recognized; bones of arm and forearm of one side are somewhat less easily traceable; it was possible to make out only indefinitely other osseous parts; for example, head and sacral portions.

The second fœtus was carefully examined to determine its connection with large fœtus. The sac of tumor evidently encloses both products of conception. The examination was continued by making incision of sac around periphery of small fœtus; after which it was raised up and the parts below second fœtus, where it rests on large fœtus, examined.

There is between them considerable cellular tissue, partly dense and fibrous. It is impossible to speak with certainty of the positive existence of a sac-wall separating the two. The sac which has been described as enclosing large fœtus was certainly continuous directly over second fœtus, and it showed no distinct prolongation inwards between the two. The presence of cellular tissue between the two structures is readily to be accounted for in the changes undergone by integuments of large fœtus.

No special examination was made to determine extent of ossification of bony parts. It was evident, however, that considerable amount of calcareous matter was present in all bony structures near periphery of tumor. The whole mass was exceedingly rigid; movement or indentation by pressure was to a great degree impossible.

It is further to be noted that, after removal of sac of tumor (at least, so far as this was done), there was presented an appearance of a second inner membrane, smooth on surface, although having fibro-cellular attachments to outer sac. Effort was made to dissect away this *inner* smooth covering, but it failed; the membrane, so called, being continuous with subjacent structures of large fœtus.

The effect of this inner membrane and its subjacent tissues was to fill interstices naturally present between the fœtal trunk and head and the folded extremities.

In the tissues subjacent to this inner membrane were found calcareous particles and masses of irregular form. This calcareous tissue was something apart from bones or their fragments.

As to the nature of the pregnancy, the committee are of the opinion that it is abdominal, originating upon the posterior layer of the right broad ligament. They are led to this opinion chiefly by the small section of tube involved in the growth, and the decided thinning of the middle and lower portion of the broad ligament, due to traction upon its posterior layer during the growth of the fœtus, and to a similar traction from its propulsion upwards by the pregnant womb in the subsequent normal gestations. Finally, there is no history of rupture.

It is hardly to be supposed that a fallopian pregnancy could proceed to full term without involving more than two inches of tube. It is doubtful also whether it can justly be said that two inches of the right tube remain to be accounted for, since, as may be recalled, it is stated in the anatomical description that the left tube, with which it, of course, was compared, was elongated. The right tube is traceable up to and UPON the under surface of the tumor, where it becomes suddenly lost, probably atrophied from pressure; there is no gradual dilatation in the direction of the tumor. The portion of tube not traceable is also closely external to the placental site, where the maximum pressure would be exerted, and where also the greatest vascularity would exist, both of which conditions are the

most favorable possible for the production of atrophy. Cases of twin extra-uterine pregnancy are decidedly rare. Among the five hundred cases analyzed by Parry it occurred but three times, and one of these cases he considered doubtful. On the other hand, twin pregnancies in which one foetus is intra-, the other extra-, uterine, constitute so large a proportion of the cases of extra-uterine pregnancy that twin gestation has been reckoned among the causes of that condition.

Considering how nearly the second fœtus escaped attention, it is permissible to suspect that similar cases may have been frequently overlooked.

J. Ewing Mears,
Morris Longstreth,
C. B. Nancrede,
E. Shakespeare,
P. E. Loder,
F. P. Henry, *Chairman.*

THE NEW (METRICAL) SYSTEM IN THE NUMBERING OF SPECTACLES.

BY SWAN M. BURNETT, M.D.,
Washington.

THE want of a universal uniform system for the numbering of spectacles has long been felt and acknowledged, and within the last decade numerous efforts have been made to supply it. Various plans, which it is not necessary here to consider, have been from time to time proposed, but none that seemed to fulfil all the requirements of the case. At the meeting of the International Congress of Ophthalmologists in Paris, in 1867, a committee was appointed to take the matter into consideration and report at the next meeting of the Congress in London, in 1872. This committee failed to agree, and no definite result was reached. The subject was discussed afterward in various ophthalmological journals, and through private correspondence, by some of the most prominent Continental ophthalmologists, the result of which has been a plan to which all who have discussed the matter have agreed. The plan is, with some slight modification, the one proposed by Monoyer, of Nancy.

This plan was adopted unanimously (though not officially) by the members of the German Society of Ophthalmology, which met at Heidelberg in 1875, and also by the International Congress of Medicine, which met at Brussels at the same time. The subject was brought before the International Congress of Ophthalmologists that convened in New York last September, by Prof. Nagel, of Tübingen, and while the members thought it best not to act in an official capacity upon it, nearly all agreed to endeavor to bring the system into general use.

Since the beginning of 1876 the system has been in use in Paris, and Wecker and Landolt have found its advantages fully demonstrated by experience. In future, in nearly if not quite all the writings of Continental ophthalmologists, where the numbers of glasses are designated, it will be in the new system, though during the transition state the old numbers will also be given.

It will thus be seen that this new system, having received the approval of such high authorities, will, in all probability, soon become generally accepted, and it is highly important that the mass of medical men, outside of ophthalmology, should become familiar with the principles of the system in order to judge of its merits properly and lend their aid in getting it established among us.

Briefly, the essential points of the new system are,—

1. *The substitution of the metre for the inch as a unit of measurement.*

2. *Numbering the glasses by their refracting power and not by their focal length.*

The substitution of the metre for the inch as a basis for measurement has many advantages. 1st, The metre is a standard which is recognized, even by law, by nearly every civilized nation in the world, and by men of science everywhere. 2d, The inch is not a uniform measure, having a different length in almost every country. 3d, The inch as a unit of measurement is too high, since it causes all the glasses in common use to be expressed in fractions. Thus, a lens with a focal distance of five inches is expressed by the fraction $\frac{1}{5}$, since it has a refracting power $\frac{1}{5}$ of that of one of 1 inch focal distance. A lens of 36 inches focal distance, because it is 36 times less in its refracting power than a lens of 1 inch focal distance, finds its numerical representation in $\frac{1}{36}$. This makes it very inconvenient when we come to add one lens to or subtract it from another. Very few men are

mathematical geniuses enough to subtract $\frac{1}{24}$ from $\frac{1}{36}$ without the aid of pencil and paper.

If we take, however, a unit so low as the metre, we will find that the large majority of glasses in common use, since they are stronger than the unit, can be expressed in whole numbers, or decimals of a whole number. For example, a lens of half a metre or 50 centimetres focal distance would be expressed by the number 2, as it is twice as strong in its refracting power as a lens of 1 metre focal length; a lens having a focal length of 20 c.m. ($\frac{1}{5}$ of a metre) would find its expression from the same cause in 5, etc.

It is only when we have to deal with glasses whose focal lengths are greater than the metre that we find ourselves involved in fractions, or decimals of a whole number. Thus, a lens whose focal length is 2 metres would be expressible as $\frac{1}{2}$ or 0.5; one of 4 metres, as $\frac{1}{4}$ or 0.25, and so on.

Should we take a lens of 2 metres, or 5 metres, or 10 metres focal length, as was proposed by Giraud-Teulon, we would be able to do away with the decimals altogether; but this would destroy the simplicity of the system, and, moreover, the addition and subtraction of the decimals 0.5, 0.25, and 0.75 (which are the only ones that are required for ordinary use) are as easy as those of whole numbers.

When we come to regard it properly, the numbering of glasses in accordance with their refracting power is not an innovation; as we have just seen in the foregoing paragraph, we have been doing essentially the same thing with the inch as a unit. If we should require a lens of twice the refracting power of the inch unit, it would be expressed by the number 2, and its focal length would be $\frac{1}{2}$ inch, etc.

We do precisely this thing in the new system. We take a lens of 1 metre focal length and call it No. 1, because it is the unit or basis for measurement; and since the lenses are to be denominated in accordance with their refracting power as compared with this unit, it is called a DIOPTRIC. A lens which has twice the refracting power of this unit (with a focal distance of 50 c.m. or 18 inches), is called No. 2, and has therefore 2 D. No. 3 has 3 D; and No. 15, while possessing 15 times the power of 1 D, has of course 15 D. On the other hand, a lens of a focal distance of 2 metres, because it possesses only one-half the refracting power of the unit, is denominated by 0.5 D; a lens of 4 metres focal distance by 0.25 D, etc.

In this manner, by taking a unit sufficiently low and designating the lenses by their refracting power, we have been enabled to accomplish another thing which has long been a desideratum in the arrangement of our boxes of trial glasses,—viz., to construct a series of lenses, the intervals between which shall be as nearly as possible the same.

The numbers of this series are given in the following table, and opposite to each number its (approximately) corresponding number in the old inch system. It will be seen that the interval between the higher numbers is 1 D, and in the lower numbers 0.5 D and 0.25 D.

No. of D.	Old No. (Approx.)	No. of D.	Old No. (Approx.)
0.25	—	5	7
0.5	72	5.5	6½
—	60	6	6
0.75	48	7	5½
—	42	—	5
1	36	8	4½
1.25	30	9	4
1.5	24	10	—
1.75	20	11	3½
2	18	12	3¼
2.25	16	13	3
2.5	15	14	2¾
—	14	15	2½
3	13	16	2¼
3.5	11	17	—
4	9	18	2
4.5	8	20	—

This series gives us all the numbers of which we have need in practice, and has, at the same time, no superfluous glasses.

Of course the No. of D does not give directly, as did the denominator of the fraction in the inch system, the focal length of the glass; but if it is desirable to know this, nothing is easier than to calculate it in the head. You have, say, a lens of 6 D; what is its focal distance? Since the focal distance is the reverse of the refracting power, we have only to divide its unit (1 metre) by 6 to have the true result; and since 1 m. = 100 c.m., $\frac{100}{6}$ = 16⅔ c.m. 7 D = $\frac{100 \text{ c.m.}}{7}$ = 14$\frac{2}{7}$ c.m. focal distance. On the other hand, if we know the focal distance in centimetres and wish to find the corresponding number of D, we have only to divide 1 m. or 100 c.m. by the focal

distance to obtain it. Example: A lens of 20 c.m. focal distance will have $\frac{100 \text{ c.m.}}{20 \text{ c.m.}} = 5$ D.

To pass from the old inch system to the new one, and to know the corresponding number of D for any lens of a given focal length in inches, is not at all a difficult matter. We have only to keep in mind that the unit corresponds to about 36 Paris inches, and therefore if we divide this by the number expressing the focal distance of the lens in inches, we have the required No. of D. Thus, if we have a lens of 9 inches focal length, the corresponding No. of D $= \frac{36}{9} = 4$. A lens of 6 inches focal length has $\frac{36}{6} = 6$ D. On the contrary, if we wish to know the focal length in inches of any No. of D we divide 36 by that No. Example: 3 D $= \frac{36}{3} = 12$ inches; or, expressed in accordance to the old system, $\frac{3}{36} = \frac{1}{12}$.

It is unnecessary for us here to point out the numerous advantages and applications of this new system to practice and physiological investigation. In the determination of presbyopia, of myopia and hypermetropia, and in the calculation of the relative refracting power of the different meridians in astigmatism, the extreme facility with which the numbers can be added and subtracted presents a recommendation which alone should insure the adoption of the system. This adoption, however, can only take place by the concurrent action of the whole profession, and it is to be hoped that our medical men, who have a reputation all over the world for taking hold of new ideas and applying them to practice, will not be slow in recognizing the great value of this new system. All those who desire to investigate the subject further, I would refer to the able and exhaustive paper of Dr. Landolt, of Paris, a translation of which can be found in the Royal London Ophthalmic Hospital Reports for May, 1876. This paper has also been reprinted in a pamphlet form by Messrs. Churchill, of London, and is for sale by William Wood & Co., New York.

1104 F Street, January 15, 1877.

Hydrate of Chloral in Cancer of the Uterus.—Having first well washed out the vagina, by means of a speculum introduce a pellet of lint saturated with a solution of chloral, one part to ten. This should be repeated every two hours. The pain, after two or three applications, becomes less, and the discharge less irritating.

NOTES OF HOSPITAL PRACTICE.

NERVOUS INFIRMARY.

CLINIC OF S. WEIR MITCHELL, M.D.

Reported by C. C. Vanderbeck, M.D.

CASE I.—The first patient before us this morning, gentlemen, is a very interesting case for clinical study, and one that will require some labor to thoroughly elucidate. The man, a pallid, weary-looking person, at present is engaged in no occupation, though for many years a miner among the various mines of Nevada. He was working chiefly in silver mines, occasionally in copper and iron, never in lead, but often or usually in damp places. He assures us that previous to four years ago he enjoyed excellent health, and that the first deviation from this condition that he noticed was a pain in the right thigh. Asking him to point out the situation of the pain, he describes accurately the course of the great sciatic nerve, and follows out its main branches. In other words, sciatica of the right side was his first trouble. Three months after this, he says, his penis became very red, and he experienced some difficulty in voiding his urine, but he had no discharge of matter. About this time the pain extended from the thigh to the small of the back. He now felt unable to work any longer, and left the mining district for his home in Philadelphia.

Watching the face, you observe every little while a jerking of the lids,—a facial tic. This he noticed slightly ten years ago, but it gave him no particular uneasiness; and we may thus explain why he tells us that his trouble began but four years ago.

These difficulties in gaining a knowledge of the history of cases are continually met with, so that the art of cross-examination is nearly as useful to the doctor as to the lawyer.

But besides his sciatica—lumbar pain and facial tic—he has also a pain which irregularly intermits. It is a superficial pain, although he calls it a headache, and it affects the infra-orbital and supra-orbital nerve-regions. The tic is painless, except when the orbital neuralgia is affecting him; then the twitching is associated with pain at each jerk. He is blind in the left eye, the result of a piece of steel entering the eye, from the pick of a fellow-laborer, in

1860; but this seems to have no causal relation to the neuralgia. He had a chancre sixteen years ago, but was never affected with alopecia, eruptions, sore throat, or any of the various constitutional outbreaks of syphilis. He has a sensation as if copper were in his mouth, but the fact that he has lately been taking iodide of potassium will explain this. The sciatica, it is to be remembered, has never left him since it began, four years ago. So that now, with the sciatic pain, the orbital neuralgia, and facial tic, he is most assuredly a nervous patient. An important point to settle is whether the syphilitic poison is at the bottom of all this trouble. The fact of there being no secondary symptoms after the chancre is against this view. Yet it is possible that after years of latency the syphilitic disease may have thus affected the nervous system. This is another case for therapeutic diagnosis, a point I referred to at some length at one of our recent clinics.

And I say this because of the extreme difficulty in being sure if nervous symptoms arise from syphilis. I have seen one case where, after ten years of absolute health, a syphilitic brain-tumor formed. I have seen two others in which the victims, both men, were utterly ignorant of ever having had syphilis, but both of them had lesions, undoubtedly, of this nature, affecting, finally, the brain; although twenty-five years of immunity had gone by in the one instance, and a yet longer time in the other. I shall, however, consider here both the character of the present malady and the fact that this man has the anæmic constitution which favors neuralgic developments. The disorders in the way of tic and neuralgia, without other head-troubles or nerve-palsies, are unlikely to be syphilitic, and yet they may be. We shall, therefore, provide for the case by ordering iron freely, and by also giving iodide of potassium in increasing doses. I should add that he has taken iron in small doses and arsenic and quinine without avail. As to the iodide, there is some need for caution. It often causes, at first, nasal catarrh, aching of the cheek-bones, and headache; but these pass away. Still, it is wise at first to give thrice a day only five grains, largely diluted. In rare cases it is very badly borne. I once spent a night of anxiety with a patient who was so poisoned by five grains of iodide that his teeth became loose, his face and neck and tongue swelled enormously, and he very nearly suffocated. Usually, by cautiously adding to the doses, even these sensitive people learn to bear it well, so that the dose may be pushed to thirty or fifty grains thrice a day. He is also to take twenty grains of iron oxide thrice a day.

The result was, as Dr. Mitchell remarked, alike instructive and amusing. Owing to an accident, the man took the iron only, and in two weeks presented himself at the clinic, with the statement that he was much better, both as regards his pain in the back and also his facial neuralgia. Dr. Mitchell did not consider that the remarkable gain in health excluded the possibility of syphilis, but concluded to continue the iron, remarking that in small doses it had done the patient no good.

Case II.—Man, æt. 28. This patient comes to us on account of seminal emissions, which he has had twice a week, at least, for ten years, and which are now, he thinks, seriously affecting his nervous system.

It occasionally happens that nocturnal emissions are charged with more evil than belong to them; but at any rate, when serious nervous symptoms are present, the relation of the emissions to the cause will bear close investigation.

History.—The patient, a cabinet-carver, describes the nervous affection thus. At times, for fourteen years, he has had dizziness: not so severe as to cause him to stagger, but to make him feel as if he might fall, and with this there is some confusion of mind but no unconsciousness; and there is also a sense of suffocation. This passes away in a half-hour or so. The conditions are intensified when in a crowd or when there is much confusion or excitement, or many things passing before his eyes.

He is frequently in low spirits, his depression amounting to a mild form of melancholia. He had a chancre two years ago, followed by various secondary manifestations of the disease. He has some eye-difficulty; he works and reads with the left eye alone. This trouble with vision antedates the vertigo and other nervous symptoms by several years. Now, gentlemen, this is an intensely interesting case, especially as regards its etiology. While syphilis and seminal emissions are sufficient to account for such a disturbance of the brain-circulation and for the other nervous

manifestations, yet may not they be more likely the result of an eye-strain? It is an important point in the history that he sets the syphilis and emissions as occurring after the nervous symptoms, while the eye-strain is said to have existed some time before.

In making an ophthalmoscopic examination, the eye-grounds do not show anything abnormal. The heart and urine must be carefully examined. Whatever the cause may be, one thing is certain, the abnormal eyesight must be corrected, as it is sufficient to keep up the unpleasant vertigo.

Let us also give him ten grains of bromide of potassium t. d., and, on account of the possible dependence of the head-symptoms upon the prostrating effects of emissions, the perineum may be galvanized, applying one pole of the galvanic current to that part, and one to the back; the direction of the current being immaterial.

We shall order him also pills of quinine, iron, and strychnia. One word in regard to the elixir of these drugs. Dr. Keating reminds me that this preparation is of a very uncertain strength, as the various chemists have different formulæ. One preparation contains one-sixtieth of a grain of strychnia to the teaspoonful, another one-hundredth grain to a *tablespoonful*. Now, we send out many prescriptions for this elixir; if the first strength be used, the dose would be right, if the second, the dose would be insufficient. There ought to be a fixed and uniform formula for a preparation containing such a potent drug.

To conclude, we give a tonic, treat the perineum with galvanism, and correct the probably or surely defective eyes.

I know of nothing more annoying than these cases of seminal emissions. There is a popular creed that any emission is a sign of disease; but, while many continent persons never have them, it is quite sure that even healthy people who thus at rare intervals get rid of the excess of a normal secretion are more or less disagreeably disturbed by them, and rise next day with a sense of lassitude and weakness which does not follow the act of coitus. Nevertheless, it is hard to regard these rare emissions as other than a natural relief. The patient may be reassured in mind if they are rare incidents,—once a month, for example. There is usually a belief that it is the loss of a vital fluid which is the evil, but I fancy it is of no more importance to lose semen than saliva. It is the peculiar orgasm which accompanies its loss which is of moment. When frequent, it leads to a state of mind which is perhaps due in part to over-anxiety, and in part to reflex influences, and which is most deplorable and only too familiar to physicians. Cauterization of the urethra is usually a failure, or worse than a failure. Long-continued daily use of a full-size bougie is of more use; but some sturdy outdoor life offers the surest relief, and of all local means galvanism is the best. But the full story of the symptoms and their treatment is too long to detain us here.

TRANSLATIONS.

Carbolic Acid in Simple Angina, Diphtheria, and Croup (*O Correio Medico*, Lisbon, 1876, p. 274).—According to Lemaire, carbolic acid water (½ or 1 part to 100), used as a gargle, is an excellent means for combating simple anginas. The sensibility of the mucous membrane and the other abnormal symptoms are promptly extinguished under the influence of this remedy. In the more severe throat affections, such as diphtheria and croup, the same agent is recommended as a gargle (½ to 100), as a cauterizer (2 to 100), as an inhalation, and as a drink. Declat tried the same remedy with good result internally, externally, and as a hypodermic injection, using in the last method 5 grammes of a solution of the strength of 1 part to 100. The observations reveal that the false membranes separate, and the subjacent mucous membrane is modified by the treatment.

The carbolic acid does not act as a cauterant, for dilution produces beneficial action; and it is not demonstrated that it exerts any chemical action on the false membranes, as some have thought. It appears most reasonable that it acts as a parasiticide, destroying the proto-organisms which constitute the fundamental part of the false membranes and which exist in the circulatory system, since the local alterations are no more than the expression of zymotic influence. J. B. R.

Case of "Athetosis."—Dr. Martin Bernhardt (*Virchow's Archiv*, Bd. lxvii.

p. 1) gives notes of a case of this curious affection, first described by Hammond, and of which less than ten instances have been recorded. The patient was a boy, 12 years of age, born of healthy parents. Two of his family, a brother and sister, had suffered with chorea. He himself was healthy up to the age of four, when he suffered from some acute affection, the nature of which was not known, but which was, presumably, one of the exanthemata. After this, some irregularity in the motion of the foot was observed, together with abnormal movements in the right hand. The patient went to school, however, and learned to write with the left hand. At the time of examination the boy was well developed and nourished. Suffered from frequent headache in forehead and temple, where the surface, particularly on the left side, was sensitive to the touch. Sight normal. Tongue thrust slightly to the right, and showed involuntary contractions. At rest, both sides of the face looked alike. The left eyelid was closed tighter, the left side of the mouth was somewhat elevated. Smiling, however, drew the mouth towards the right, and occasionally the same movement was made during talking.

The entire left half of the body preserved its mobility and sensibility intact. The right shoulder- and elbow-joints were freely moved, only the movements here seemed somewhat weakened and slow. No involuntary movements of the head, shoulder, and forearm were observed. With the exception of occasional severe pain in the right upper extremity, nothing abnormal was observed on this side. Walking any distance exaggerated the deformity of the left foot (pes varo-equinus). He could only stand on the right foot alone. The recently described "knee-phenomenon" was observable on both sides. The "foot-phenomenon" was absent on both sides, or at most barely noticeable. When the patient was quietly sitting, while his attention was absorbed in conversation, the right hand with its fingers appeared at perfect rest. The moment the patient's attention was directed to these members, a curious series of movements of the right fingers began. In rapid succession the fingers were adduced and abduced, flexed and extended, particularly the thumb, the little finger, and the index finger, while the others remained quiet. The hand itself seemed, in the mean time, immovable on the wrist, but on the flexor and extensor sides of the right forearm a continuous play of the muscles could be observed, the muscles themselves and their sinews appearing in continually changing relief under the skin. The sensibility of the right side was less than that of the left. When the patient tried to suppress these muscular movements by an exertion of the will, they either continued unchanged or became more violent. The right forearm was larger than the left, a condition which could only be ascribed to the continual involuntary muscular movement, since the left alone had been in active use since early childhood. Slight movements were also observed in the right foot, continuing even during sleep. The patient's condition had not changed during the seven years previous. Treatment by electricity, tonics, etc., continued during some months, seemed to exercise little or no influence upon the affection. x.

Functions of Nerves discovered with the Aid of Electric Currents.—M. Onimus (*Soc. de Biologie: Le Mouvement Méd.*, 1876, p. 699) has undertaken a series of experiments upon the excitation of nerves by the induced current. The pneumogastric nerve first occupied his attention. This, as is known, has been regarded as a cardiac inhibitory nerve. Onimus's experiments show that twelve to eighteen excitations per second are required to arrest the action of the heart. A less number reduces the number of pulsations, but renders them more energetic. One shock per second, far from arresting the heart's action, causes one contraction more than the normal after every shock. Thus, in a curarized frog, one shock per second caused the heart to make sixty pulsations per minute, while in the normal condition it had only made fifty pulsations. These investigations go to show that, instead of arresting the heart's action, excitation of the pneumogastric augments the number of its pulsations. The same fact has been observed regarding all the organic rhythmic systems: thus, the peristaltic contractions of the large intestine, which average about eighteen per minute, are suspended under the influence of the constant current, and are increased in number and energy when only a limited number of shocks are transmitted. The action of the pneumogastric, therefore, is not especial, or different from that of other nerves. It simply serves to connect various ganglia. x.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, MARCH 3, 1877.

EDITORIAL.

THE UNITED STATES PHARMACOPŒIA.

THERE are on the table before us two pamphlets, one proposing and the other opposing certain changes in the method of revision and in the character of the United States Pharmacopœia. The first of these is by Dr. Squibb, of New York, and will, we presume, be furnished upon application; the second is from the pen of the chief editor of this journal, and will be sent to any physician who has sufficient interest to enclose the request, his own address, and a three-cent stamp to J. B. Lippincott & Co. The subject is one of the gravest importance, and should command the attention of the whole profession. We conceive it to be the duty of every one who expects to be a delegate to the next Convention to read carefully both of these brochures and to endeavor to get all the light possible before going to Chicago. Unless this is done, there is danger that an unwise measure may be carried, or a wise measure lost, through the personal predilections of some popular leader or leaders. It is well known that the Pharmacopœia is now revised by a Committee of Revision, who are every ten years reappointed by a National Convention meeting at Washington. The first proposition of Dr. Squibb is that the American Medical Association shall by resolution relieve the National Convention "from any farther acts of ownership, control, or management of the Pharmacopœia." Stated in this blank way the proposed action looks ludicrous, and no amount of fine writing or of plausible schemes as to the method of securing possession can cover over the fact that the core of the matter is the assumption by the Association of property to which it has no legal and, from one point of view, no moral right. A single member of the Committee of Revision, much more the Committee as the Whole, could by legal injunction undoubtedly bar the whole proceeding: the very name United States Pharmacopœia is protected by the law of copyright. The Association by the passage of such a resolution would undoubtedly expose itself to a snubbing not undeserved. Suppose the National Convention say, We do not choose to be relieved: what then? The Association must humble itself, or if it persist there will be two national Standards,—one known as the United States Pharmacopœia, the other as the ——

It is plain that nothing but imperative necessity should impel the American Medical Association to incur the risk of such a condition. Does such necessity exist? Certain defects in the present Pharmacopœia are supposed to furnish it. Our national Standard is not perfect, but, on the whole, it is very good, and, so far as our observation goes, most eminent pharmacists will support the assertion that it is superior to that of Great Britain. More than this, no asserted defect of the Pharmacopœia can be a valid reason for the proposed interference. The National Convention is composed of experts chosen from all parts of the country; and if any eminent pharmacist or physician cannot demonstrate to it the superiority of his ideas over the old, it is probable that his ideas are not correct. A decision rendered by men of especial knowledge and training, selected for the purpose, is far more apt to be a wise one than that reached by such an assemblage as the American Medical Association, popular and general rather than especial in its character. Were it a question of eye-surgery, whose verdict would command respect, that of the American Medical Association or that of the Ophthalmological Congress? and what

would be thought of an appeal from the Congress to the Association? Every change in the character of the Pharmacopœia, and in the method and frequency of its revision, proposed by Dr. Squibb, the National Convention is perfectly competent to adopt. If we mistake not, some of them he has already laid before that body. Whether he has done so or not, maintained harmony, one standard, retention of present values, and a wise decision, would probably be reached by such reference; whilst an attempt on the part of the Association to assume authority means discord, doubtful decisions, upsetting of the work and customs of half a century, and, finally, two standards and the multitudinous curses of such a condition. In an assemblage of unlimited numbers and very limited time, like the American Medical Association, no full, prolonged debate is possible. It seems very folly to expect careful consideration and wise deliberations on such a subject as the present: the whole time of meeting would not suffice.

Dr. Squibb urges that the National Convention is not really representative of the country. The law of its existence prescribes its composition as of delegates from "the several incorporated State Medical Societies, the incorporated Medical Colleges, the incorporated Colleges of Physicians and Surgeons, and the incorporated Colleges of Pharmacy throughout the United States." This is a more thorough representation than that of the American Medical Associations, which receives delegates only from State and County Medical Societies. If the numbers of the National Convention are in practice small, it is because there are comparatively few men in the United States fitted by culture and experience to discuss the questions of the Pharmacopœia. Yet at the last meeting, with the whole South aloof, there were represented thirty-one incorporated bodies. We repeat it, the profession had far better trust its Pharmacopœial interests to the decisions of such a body than to those of the American Medical Association.

It will be answered, that it is not the American Medical Association but its Pharmacopœial Council which is to decide questions concerning the Pharmacopœia. Probably this is what Dr. Squibb intends; for he proposes the following by-law: "There shall be a Council established, to be called 'The Pharmacopœial Council of the American Medical Association,' for the sole purpose of taking the entire charge, control, and management of the Pharmacopœia of the United States of America, under the ownership and supervision of this Association; for the benefit and interests of the general medical profession, as represented in this Association." This by-law certainly indicates that Dr. Squibb expects that all Pharmacopœial questions shall be decided by the Council, which is to be composed of a president, appointed by the Association, a representative of the medical service of the army and navy respectively, appointed by the respective bureaus, and two pharmacists, appointed by the American Pharmaceutical Association. How will this work in practice? As the proposer of the scheme, and as the most capable member of the body, Dr. Squibb will undoubtedly be appointed president of the Council. To him, therefore, is the American Medical Association asked to commit the interests of the whole civil profession, from the Pacific to the Atlantic, from the Gulf of Mexico to the Canada boundary line. For this purpose revolution is to be let loose and a career of contention entered upon whose end no man can foresee.

In the last Committee of Revision the general medical profession was represented by Drs. George B. Wood, Joseph Carson, Robert Bridges, of Philadelphia; W. Manlius Smith, of New York; John C. Riley, of Washington; Thomas Jenkins, of Louisville; Charles A. Lee, of Buffalo; J. S. Welford, of Richmond; and F. Wentzell,

of California. It may be that the medico-pharmaceutical lore of the country would be better represented by Dr. Squibb than by such a body of men; but the superiority does not at first glance appear sufficient to warrant the confusion and risk of change.

Under all the circumstances it becomes the imperative duty of every medical journalist in the country to study closely the sayings of Dr. Squibb in regard to the matter, and to endeavor to discover what sort of a national Standard he would fashion. In our next issue we hope to be able to lay before our readers the result of such an investigation.

LEADING ARTICLES.

RECENT PROGRESS IN THE TREATMENT OF VENEREAL DISEASES.

II.—SYPHILIS.

(Continued from page 228.)

CLOSELY connected with the inunction method of treatment is that by means of the mercurial bath and fumigation. As regards the former, there is no doubt of its efficacy in infantile syphilis, and it is to be recommended in preference to inunction, as equally convenient and decidedly more pleasant in the case of young children. Ten grains of corrosive sublimate in about a bucketful of warm water serve for one bath. The simple precaution of tying the waist of a flannel skirt around the child's neck and spreading it over the tub will prevent danger from splashing the liquid or conveying it otherwise to the mouth. This bath may be given once or twice a day, and may be kept up until all symptoms of syphilis have disappeared, and for some time longer.

Fumigations do not continue to enjoy the favor which was at first gained for them by the active advocacy of the late Langston Parker* and other prominent syphilographers in this country as well as abroad. Heorteloup† has recently written on the subject, recommending fumigations (of calomel) — 1, administered alone in cases of early ulcerating rashes, mucous patches, etc.; 2, combined with iodide of potassium in cases of later lesions, tubercular, ulcerating pustulo-crustaceous, and deep ecthyma.

When a large number of ulcerative lesions are scattered over the surface, fumigation would seem to be the preferable method, as combining a certain local stimulating effect with the constitutional effect of the mercury. A case has been recently reported in which local fumigation of the leg in obstinate syphilitic ulcer proved of marked benefit. The plan of fumigation is, however, a difficult one to carry out, excepting in a hospital; and so, in spite of numerous modifications for its more convenient use, it seems to be losing rather than gaining favor at the present time.

The indirect treatment of infantile syphilis by means of the breast-milk of the human female under anti-syphilitic treatment, or of the milk of animals to whom specific remedies have been administered, may be considered as still *sub judice*, testimony on the facts being of the most conflicting character. Kahler‡ has made a number of experiments by electrolytic analysis, but has failed to find mercury in the milk, even when inunction was used so thoroughly that existing syphilitic lesions in the woman were being rapidly cured. He admits that in certain cases infants to whom no mercury has been given improve while nursing a mother taking that agent. Klink§ arrives at conclusions exactly the opposite of those by Kahler. He relates the case of a woman nursing her child while undergoing the inunction treatment, in whom mercury was undoubtedly found after the thirteenth inunction. The child, also syphilitic, was cured. Better methods of analysis than those heretofore employed are necessary to settle the question.

Two plans of treatment remain to be described,—the abortive and the expectant. The hope of cutting off the disease, of averting syphilis at its very beginning, has always been indulged, and the means suggested to this end have been very numerous. Cauterization with the actual or galvanic cautery, with chemical applica-

*The Modern Treatment of Syphilitic Diseases. Fifth Edition, 1871.

†Traitement de la Syphilis par les Fumigations mercurielles. La France Médicale, Nos. 43 and 44, 1875.

‡Untersuchung der Milch von Frauen während der Inunctionscur. Vierteljahrsschr. f. die Prakt. Heilk., xxxii., 1875.

§Untersuchungen über den Nachweis des Quecksilbers in der Frauenmilch während einer Einreibungscur mit grauer Salbe. Vierteljahrsschr. f. Derm. u. Syph., Heft 2, 1876.

tions, extirpation, enucleation, etc., may be mentioned. "No one, however," says Sigmund, "who has followed up a number of cases through series of years will have any hope from such measures." Indeed, in the light of our present pathology it seems almost incredible that such should be thought of for a moment. Excision of indurations, however, may be practised with a view to prevent phymosis, etc., as well as the formation of vulnerable scars, and will often aid in the cure of stubborn local troubles and thus shorten the course of the disease.

The expectant plan of treatment has its advocates, who allege the existence of mild forms of syphilis spontaneously curable and neither requiring anti-syphilitic treatment nor likely to be benefited thereby. How such cases are to be distinguished with certainty in their earlier stages has not yet been clearly demonstrated; and in this lies the weakness of the theory. Fournier goes into the subject with great thoroughness, and with the most convincing logic shows the burden of proof to lie with the advocates of the expectant plan, and the terrible responsibility which they must bear if their theory should prove without foundation.

It may be observed in the foregoing remarks how little allusion has been made to the treatment of syphilis by iodine, almost all that has been said having relation to the various forms and uses of mercury. This may be explained by the comparatively inferior and limited sphere to which iodine has in recent years been relegated. Within certain limits iodine is invaluable; but these limits seem to be more defined, if somewhat narrower, than formerly.

The chief progress which has been made in the general therapeutics of syphilis during the last ten years has been in the following ways: increased clearness in the views held regarding the period at which the methodical general treatment of syphilis should begin; more certainty in the methods of treating syphilis in pregnant women and in children; greater success in the treatment of gummatous, particularly nervous and visceral, syphilis; more active measures in prophylaxis.

According to Sigmund, the period at which the general treatment of syphilis should begin has now been decided by extended observations to be the moment at which various symptoms show themselves for the first time at a distance from the point of origin. Jonathan Hutchinson,* however, recommends that mercury should be given as soon as the chancre shows any induration, and asserts that under these circumstances many cases never have any secondary symptoms. These opinions are not so different as they appear at first glance. If the induration can be established, it is as much a sign of the generalization of the poison, and essentially as distant from the origin of the disease, as if it were at the remotest extremity of the system.

In reference to the treatment of syphilis during pregnancy, Sigmund regards inunction as the best method. In his experience, many women on whom the papular lesions have already appeared have been cured of these manifestations, and have given birth to living children showing no signs of disease, and continuing to live. Treatment begun after the sixth or seventh month is not so hopeful; but still, even this often succeeds, and, with proper local treatment, none of those accidents which are otherwise so frequent about the genital passages need be looked for. With respect to the treatment of syphilis in children, much may be expected from placing them under the best hygienic conditions. Without this nothing can be hoped from treatment alone. This principle cannot be too strongly asserted. Next to the nourishment, which in infants should always be breast-milk, come, in Sigmund's opinion, preparations of the iodide of iron and baths of corrosive sublimate. The gummatous—tertiary—forms of syphilis have long been treated by iodide of potassium: it is, in fact, one of the axioms of the French school of dermatology that mercury is to be used in the earlier stages of syphilis, and iodine in the later. Sigmund, however, has within the last year or two treated a series of cases of serpiginous ulcers, gummata of the nose, bones, etc., by inunctions of unguentum hydrargyri. These patients had previously taken enormous doses of iodide of potassium, and had also used mercurial frictions in vain. Sigmund attributes his success in these instances to the careful use of proper hygienic measures, together with the most assiduous local treatment. In extensive suppuration of gummatous ulcers, as well as in cases of diphtheritic exudation upon the external skin, concentrated solutions of sulphate of copper (1 : 3), carbolic

* Use of Mercury in Syphilis. Lancet, 1874.

oil (1 : 6 linseed oil), or paste (1 : 5 linseed oil and gypsum or chalk) are recommended by Sigmund as local applications. The diseased localities are to be very carefully cleansed and covered up two or three times a day with empl. saponis, empl. hydrarg., āā part. æq., in such a way that every portion is touched. As to the mouth, nose, pharynx, etc., they should be thoroughly and frequently cleansed with solutions of carbolic or salicylic acid, permanganate of potassium, and the like, and also pencilled with the glyceroles of these substances.

In the treatment of visceral and nervous syphilis, the combination of hydro-therapeutics and the use of mineral waters, with the administration of mercurial preparations and iodine, now so general, together with the increased certainty in diagnosis of these affections, renders their cure much more usual than formerly.

Finally, with regard to the method of administration of mercury, considerable difference of opinion exists; some syphilographers, as Fournier, asserting the advantage of short, interrupted courses of treatment; others, as Sigmund, favoring the continuous exhibition of small doses of this medicine. The latter plan of treatment is supported by the investigations of Keyes* upon the blood of syphilitic patients taking mercury. This observer found that minute doses of mercury increase the number of red corpuscles and act as a general tonic upon the system, and that in such doses the drug may be continued indefinitely without losing its beneficial effect. A. Van Harlingen.

CORRESPONDENCE.

New York, February 1, 1877.

To the Editor of the Phila. Medical Times:

DEAR SIR,—Dr. Charles Heitzmann, at the January meeting of the County Medical Society, read a paper on "*The Cell Doctrine, in the Light of Recent Investigations*," in which he attempted to prove that the now generally accepted views on this subject were erroneous, and had been comparatively barren in the practical result of elucidating much that we ought to know, both in physiology and pathology; and then proceeded to detail with minuteness his own *bioplasm theory*, according to which the ultimate form of organic matter is not a cell, but a granule or corpuscule of living material or protoplasm. He stated that he had come to this country expressly for the purpose of teaching the new doctrine, and that he was confident that ere long it would supersede that which is now so universally received.

At the last meeting of the Medico-Legal Society, February 7, Dr. Alfred L. Carroll, of New Brighton, Staten Island, read an able and interesting paper on "*The Difference between Insane Criminals and the Criminally Insane*." Without attempting to define insanity, a matter which he considered it impossible to do satisfactorily, he went on to say that its aspect most interesting to the public is that which relates to criminal actions, especially to homicide; since it has latterly become the fashion with counsel for the defence to impress upon jurymen that killing is *prima facie* evidence of mental unsoundness, and to retain so-called medical experts as special pleaders, not to give an impartial scientific opinion, but to concoct the most ingenious case for the defendant. It is beyond question, however, that there are numerous phases of insanity clearly distinguishable by a professional observer, but not easily to be perceived by an unpractised eye; and the dispute between law and medicine on these obscure forms of mental disease arises from the fact that the legal notion of insanity remains unaltered from a past age, when nothing but total dethronement of reason was recognized as lunacy, while modern medical authorities on the subject have learned to detect early stages and less marked varieties. The law has remained stationary in regard to it; but medicine has been making constant advances in its study. The former makes the mistake of regarding the insane (1) as necessarily unable to distinguish between right and wrong, and (2) as necessarily suffering from delusion. With our present knowledge this is evidently untenable and absurd. The kleptomaniac, for instance, knows that he is doing wrong, but has not the strength of will to resist the temptation. But even supposing forensic doubts of diagnosis were set at rest, the question would remain whether all these less defined cases of lunacy ought to be excluded from the operation of criminal law; and this question would be unhesitatingly answered in the negative by some of the ablest alienists, who, when they certify to a patient's insanity, do not necessarily mean to imply that he is unaccountable for any and all of his actions. In other words, there is a distinction to be drawn between insane criminals and criminal lunatics; and it is quite possible that a person whose insanity would absolve him from responsibility in one direction may commit crime from a sanely criminal motive, if such an expression is permissible. In any given case the first question to be considered is whether the criminal act was the direct outcome of the actor's insanity; the second, whether, if so, the person was incapable of re-

* The Effect of Small Doses of Mercury in Modifying the Number of the Red Blood Corpuscles in Syphilis. By E. L. Keyes, M.D. Am. Jour. Med. Sci., Jan. 1876.

sisting the insane prompting. Even Maudsley admits responsibility in some cases, and he further says, "There can be no doubt that the insane inmates of asylums are to some extent deterred from doing wrong by the fear of what they might suffer."

Dr. Carroll then went on to speak of homicide in its relations to various forms of mental disorder, treating first of dementia, imbecility, and chronic mania, and then passing on to acute mania, which, he said, occurs in those of a neurotic temperament, and is never developed without marked premonitory symptoms.

Partial insanity is the great ground of medico-legal disputes, and has not infrequently served as "a letter of marque to permit unlimited ruffianism."

The question is, Is the act or crime committed in the *line* of the actor's insanity? If not, he is legally responsible for the deed.

Transitory insanity, the speaker said, was, as a rule, to be referred to epilepsy.

Morbid impulse is never met without antecedent or concomitant symptoms of insanity, which cannot fail to be perceived if care is observed. Therefore if a person feels a strong desire to commit murder, for instance, and cannot overcome that desire, it is his duty to put himself under proper restraint at once. If in any case there are no antecedent symptoms, it is safe to conclude that it is not true morbid impulse, but only quick temper; and it behooves us always to examine very carefully whether there is not a motive for any given action.

On the question of *moral insanity* the speaker agreed with Blandford in denying that the absence of the moral sense proves or constitutes insanity any more than its presence proves sanity. In any particular case the insanity is to be judged by other acts.

Dr. Carroll quoted freely from the best-known alienists (especially from Maudsley, who of all modern authorities is inclined to be the most lenient in his judgment) to show that there has been a gradual tendency to fix legal responsibility more exactly, and that the mere fact that some form of insanity is proved does not exonerate the person from liability to punishment. In conclusion, he maintained that even where murder is apparently motiveless we should insist that the murderer be segregated from the community for life, so that it will no longer be possible to have such a one committed to an asylum as insane, and almost immediately afterwards set at large, on the ground that his insanity has been cured, since all authorities agree that homicidal mania, from whatever cause arising, is very apt to recur. The wisest plan, he thinks, would be to refer all testimony concerning mental unsoundness to a permanently organized commission in lunacy, from whose report an intelligent decision might be reached. A step in the right direction was made by the New York Act of 1874, directing that the plea of insanity be received only at the time of the arraignment, and empowering the court to appoint a commission of inquiry; but much still remains to be done to bring law and medicine into equitable harmony. Meanwhile, jurymen and jurists will do well to bear in mind that insanity, if genuine, is shown in other ways than by a single act, that hypothetical questions are useless (each case requiring thorough examination on its own individual merits), and that a person whom no physician would hesitate to pronounce insane may nevertheless commit crime with a reasoning, culpable purpose.

After the discussion on Dr. Carroll's paper had been concluded, an interesting communication was read from Dr. Edward G. Loring, in reply to a number of inquiries which had been submitted by some of the members of the Society (not medical men) at the last meeting, in reference to the eyesight of the public-school children. Among them were the following:

Is bad air injurious to the sight?

What is the effect of good or bad type on near-sightedness?

What is the effect of insufficient light?

From what direction should the light come?

In answer to the first, Dr. Loring showed that bad air had a direct tendency to produce even grave affections of the eye, like purulent ophthalmia, as is proved by the fact that recovery not infrequently takes place in these cases when pure air is substituted, without the use of any other means whatever; and in answer to the last, that the light should come from a little above the level of the eye and fall over the left shoulder.

At the last two meetings of the Academy of Medicine the topic of discussion has been: *The Relations between Croup and Diphtheria, and the Value of Tracheotomy in each.* On the first evening the principal speakers were Drs. A. Jacobi, Austin Flint, Sr., and J. Lewis Smith; but nothing especially new or notable was developed in regard to this frequently debated subject. The first-named doctor contended for the identity of croup and diphtheria, while the other two were opposed to this view; though Dr. Smith acknowledged that it was often impossible to make a differential diagnosis when diphtheria was prevalent in a community, and stated that he believed the two were not infrequently associated at such times. Dr. Jacobi spoke most at length on tracheotomy. He had performed this operation about two hundred times, he said, with very fair results, and stated that the great and only indication which guided him in resorting to it was imminent danger of suffocation. When this was present he never hesitated under any circumstances to tracheotomize the patient.

On the second evening, Dr. John C. Peters, who is always indefatigable in such research, gave some very interesting historical facts in regard to diphtheria, which he said there was every reason to believe was by no means a

disease of modern origin. On this occasion he devoted himself principally to a résumé of its outbreaks and course in this country. In the years 1633 and 1663 a disease of the mouth and throat corresponding exactly to it made its appearance on two vessels coming across the Atlantic from England. In Jedediah Morse's "History of New England" the great epidemic of 1735 (Dr. Douglass's) is described. It was called the "throat distemper," and was characterized by the appearance of white or ash-colored spots in the fauces. In many of the cases there was also a rash: so that it would seem to have been associated with scarlatina, as has so often been the case since then. Dr. Peters then quoted from Gallup's "History of Vermont" to show that through the eighteenth century, and in the beginning of the nineteenth, various epidemics of the disease occurred, not only in that State, but also in New York, Pennsylvania, and Massachusetts. In 1814 there was a very severe outbreak of "putrid sore throat" in Prince George's and other counties of Virginia, and one family was mentioned in which nine out of its ten members were carried off by it. The first cases of diphtheria, distinctly recognized as such, ever reported in America are recorded in the Proceedings of the New York Pathological Society for 1845. On July 11 of that year Dr. Willard Parker presented to the Society the tonsils, larynx, and trachea taken from a patient who had died of the "diphtheritic croup of Bretonneau," mentioning that the disease had then for some time been prevalent in this city, and that he himself had seen ten cases of it. Its chief characteristic was the deposit of false membranes, which not only covered the tonsils, but lined the whole of the larynx and trachea as well. Depletion was shown to be positively injurious, and the treatment by calomel and senega proved the most successful. Drs. Sabine and Merton also related cases. In 1846, Dr. Peters himself reported a case of diphtheritic croup at the Pathological Society, in which the larynx and trachea were filled with false membrane. From this date the disease was lost sight of in this city until 1857, when two cases of death were reported from it. In 1858 there were five deaths from it, and fifty-three in 1859, when Dr. Jacobi was the first to call attention to it. During 1860 no less than four hundred and twenty-two lives were lost by it; and at this time a report concerning it was issued by the city health inspector. In this it was stated that diphtheria (which was transported thence from France) was prevalent in England in 1858. It was not known how it came to New York. The report went on to say that it was not a contagious disease, but that it seemed to have some relation to scarlatina. Furthermore, it stated that croup, diphtheria, and scarlatina seemed to be "wonderfully mixed up" in this city, and that sometimes all three appeared on one death-certificate by the physician.

The following figures show the mortality from croup and diphtheria respectively in New York since 1860:

Year.	Croup.	Diphtheria.
1861	685	453
1862	685	504
1863	985	981
1864	754	734
1865	449	589
1866	257	334
1867	76	38
1868	342	277
1869	255	158
1870	421	308
1871	457	238
1872	675	446
1873	734	1133
1874	594	1665
1875	758	2311
1876	527	1750

The epidemic of diphtheria seems to be slowly but steadily declining at the present time.

At the last meeting of the Neurological Society, a learned and elaborate paper on the *Psychological Pathology of Progressive Paresis*, which was illustrated by specimens and drawings exhibiting the course and microscopic changes of this disease, was read by Dr. Edward C. Spitzka. The drawings, which were executed by himself, showed the gentleman to be as admirable an artist as he is an accomplished neurologist.

The report of the health officer of the port, Dr. S. Oakley Vanderpoel, for the past year presents several points of special interest. In a season rendered unusual from the number of places in which *yellow fever* prevailed as an epidemic, as well as from its presence at Dix Island, in the Lower Bay (except during the month of May), from February until the latter part of October not a properly authenticated case reached the city by way of the sea, nor was a sailing-vessel or steamer so restrained as to retard her regular sailing. From the various Southern and West Indian ports where yellow fever has prevailed more or less in an epidemic form during the past season, three hundred and sixty-three vessels arrived between the 15th of May and the 15th of October, ninety-nine of which had the disease on board, either while in port, on the passage, or after their arrival here. Three hundred and fifty-five cases of yellow fever were thus reported,—two hundred and thirty-nine at the port of departure, sixty-seven on the passage hither, and thirty-nine in this port. Sixty patients were treated in the hospital, of whom thirty-nine had yellow fever, while most of the others were suffering from some form of malarial fever resembling it. Of the former, eleven died, showing a favorable percentage of recovery, which Dr. Vanderpoel attributes, in a great degree, to the airy and healthy location of the Quarantine Hospital.

The report goes on to say, "The presence of yellow fever at Brunswick, Savannah, and Charleston, all lying within the average time assigned as the incubation period of the disease, rendered it necessary that some arrangements should be made whereby the commerce from these ports should remain unrestricted. It was directed that no passengers be taken on vessels coming from these ports. This left me to deal with the crew and cargo only. Full hygienic precautions were suggested to the steamers plying between Savannah and New York, which, on their part, were faithfully carried out. The usual course was pursued with reference to the vessel and cargo as with all vessels coming from infected ports. The vessels made their trips during the whole epidemic, with their accustomed regularity: indeed, from reasons about to be stated, extra vessels were placed upon the route. So far from New York being a loser, she was a gainer, in a commercial aspect, from the fever epidemic at Savannah. She was the only port on the Atlantic coast which permitted free commercial intercourse with the infected city." "The consequence of this embargo was that not only was an excess of cotton sent from Savannah to this port, as compared with previous years during the same period, but all the vessels trading from Charleston, Wilmington, and even Norfolk, were tasked to their utmost capacity. Sanitary measures and commerce need not, therefore, be antagonistic; and in this instance the former aided the latter. Though nearly one thousand deaths from yellow fever occurred in Savannah, no well-authenticated case reached the city of New York, except those of two gentlemen who came by rail." "Fewer cases of ship fever and smallpox have arrived than for many years previous; but this is chiefly attributable to the great falling off in immigration, and consequently the smaller percentage of persons liable to be infected."

Dr. James O. Pond, now over eighty years of age, was recently presented with a series of complimentary resolutions, elegantly engrossed and framed, on the occasion of his retiring from the responsible position of treasurer of the Academy of Medicine, an office which he held for twenty-seven consecutive years.

PERTINAX.

IN Europe the fixed salaries of medical professors range from $450 to $2000. Prof. Recklinghausen receives the highest: he gets, with the fees of the students, more than $8000. —*Lyon Médical*, October 15.

DR. ELY MCCLELLAN, U.S.A., calculates the cost of the late yellow-fever epidemic to the State of Georgia as 5,609,857 dollars. 5,609,857 dollars and 26.5 cents would, we think, be more accurate.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, DECEMBER 14, 1876.

THE PRESIDENT, DR. H. LENOX HODGE, in the chair.

(Continued from page 238.)

Embolic pneumonia. By Dr. JOHN GUITÉRAS.

J. W., æt. 45, admitted to the hospital Nov. 27, 1876.

Both parents died of consumption about the age of 60. He has lost four sisters and two brothers from the same disease.

He has always been a healthy man, but very intemperate for the last three years.

Notes taken Dec. 1.—Ten or twelve days ago he contracted a heavy cold, which did not confine him to bed until the day of admission.

Since admission, the pulse has been frequent, considering the slight febrile movement, and acceleration of respiration. There has been more or less constant and distressing hiccough. To-day his body is covered with a profuse perspiration. He is drowsy, and there is some wandering delirium.

By physical exploration I detected an area, about one and a half inches square, at the margin of the chest and within the line of the left nipple, where marked blowing breathing and dulness were present. Loud sonorous breathing was heard over the rest of the chest.

On the 2d there is prune-juice expectoration, and a friction-sound is heard by pushing the stethoscope under the ribs. The bronchial breathing is rendered indistinct by moist crackling at the circumscribed spot of consolidation. Pulse 116. Heart-sounds normal.

On the 3d, expectoration continues. The fluid under the small area mentioned breaks up into larger bubbles. The consolidation is extending upwards. Subsequently this extension of the inflammation continued, the typhoid state became more marked, and the patient died of œdema of the other portions of the lung. At no time was the expectoration fetid.

Dec. 3, evening, P. 108, R. 40, temp. 100°. 4th, morning, P. 116, R. 25, temp. 101°; evening, P. 112, R. 44, temp. 101°. 5th, morning, P. 108, R. 44, temp. 99⅗°; evening, R. 48, temp. 98°.

Post-mortem examination.—The diaphragmatic and pericardial pleura were minutely injected, and the seat of recent adhesions, especially towards the left.

The right lung was decidedly œdematous. The inferior left lobe was solid (red hepatization) in the central portion, surrounded towards the pleura by a layer of healthy lung nearly one inch deep. This explains the absence of signs of consolidation in the back.

Near the inferior border of the upper lobe, anteriorly, an area about one and a half inches in diameter, of a black color, was seen under the pleura. A section of this lobe was made through this spot, revealing a wedge-shaped cavity, with the base at the pleura and the apex not far from the root of the lung. It contained the dark, grumous detritus of gangrene, though odorless. The walls of this cavity were regularly excavated, showing that they were formed by the connective-tissue partitions between the dead and living lobules. The blood-vessel entering the apex of this wedge was found occluded by a white, fibrinous embolus, which was not yet adherent to the arterial walls. The upper portion of this lobe presented the granular section of red hepatization; but the other portions of the lung surrounding the cavity presented a marbled appearance. The dark connective-tissue partitions were visible, separating lobules of more or less reddish and whitish hues: in my opinion they were lobules in the different stages of catarrhal inflammation and caseous degeneration.

The anterior leaflet of the mitral valve presented a patch of atheroma, evidently not interfering with its function. The right auricle was filled with a large ante-mortem clot. Some shreds from it extended into the ventricle, becoming entangled with the tendinous cords. The clot was quite adherent to the walls, firm, white, and somewhat laminated.

The other organs were healthy. No tuberculosis.

Remarks.—Two very interesting points present themselves for discussion,—viz., the origin of the clot, and the significance of this catarrhal inflamation. In regard to the first, I suggest that the primary trouble was a bronchitis and catarrhal pneumonia (it is to be remembered that the patient was peculiarly predisposed to such form of inflammation by a hereditary taint); that this pneumonia may be sufficient cause for the formation of the clot in the right heart; that from hence the embolus was washed into the pulmonary circulation, causing gangrene of parts already in danger of slow death from caseous degeneration. The other question refers to the importance of this specimen as an illustration of the inflammatory origin of phthisis. The inflammation had spread from lobule to lobule. The lobules nearer the larger bronchi seem to be further advanced in the process of caseous change. The patient had only been ill three weeks, and the degeneration is not complete,—yet sufficiently so to make it very probable that either acute or chronic consumption of the lungs would have taken place had not the end been hastened by the gangrene and the croupous pneumonia of other portions of the lung. The latter seems to have been due merely to extension of the inflammatory process. How often may this combination of the two forms of pneumonia exist in those cases of adults where we find phthisis following pneumonia,—a pneumonia that we believe to be solely croupous or lobar?

The hiccough is accounted for by the irritation of the terminal fibres of the phrenic, and also of its trunk as it passes between the pericardium and lung: indeed, here the evidences of inflammation were much more decided.

Dr. C. B. NANCREDE thought it not impossible that there might be some other starting-point for the thrombus. Thus, there are several cases now on record where a simple bruise of the thigh has resulted in a most extensive phlebitis, which has not even been suspected; and so it might have been in this case. He did not understand why the embolus need start in the lung, go thence to the heart and back to the lungs again, as the anatomical arrangement of the capillaries of other organs would be more likely to have arrested it. This case seemed interesting in connection with the pathology of pyæmia.

Dr. N. had been struck with the exceedingly mechanical views which seemed to impress most pathologists. He thought that much more might be accomplished if we followed the plan of John Hunter and studied first the physiology of an organ before we tried to understand its pathology. If, for instance, we examine the physiology of the lungs, we find that in them the blood is aerated and that here a large amount of carbonic acid is eliminated. What is the result of interference with this function? See what is found in one disease where there is not sufficient oxygen present to get rid of a comparatively innocuous substance. Whether there be deficient oxidation on the one hand, or too much sugar on the other, to permit its oxidation in the lungs, certain it is that in glycosuria curious conditions result, among which are furuncles and other suppurative affections, even spontaneous gangrene of an extremity having been observed. If we examine the functions of the liver, we find it gets rid of a large amount of carbon and hydrogen in the shape of the bile, that it is a sugar-forming organ, that it has to do in some degree with calorification, and, finally, that it converts the crude albuminose into albumen. The liver in like manner excretes a substance, cholesterine, which when retained in the blood for a prolonged period has been known to set up symptoms similar to those of uræmia.

It was hardly necessary, Dr. Nancrede said, to allude to the depurating function of the kidneys; but he would direct attention to those inflammations of serous membranes found in kidney diseases, and especially would recall the fact that the arthritic affections in pyæmia have their origin in the same kind of membrane that is so frequently spontaneously inflamed in Bright's disease.

The skin likewise has an important part in excretion, acting to a certain extent vicariously to the kidneys,—indeed, so actively in certain

cases of acute suppression of skin-function that the skin has been found covered with a white pellicle of urea. Now, may not all these facts concerning the functions of the various organs have something to do with pyæmia?

One of the most recent surgical authorities remarks that the views of Virchow and his school are not satisfactory to him, and he believes that pyæmia and septicæmia are the result of the same cause, in the one case (septicæmia) the patient dying too soon to have any secondary complications, while in the other the same cause favors the occurrence of emboli. Dr. N. said that he wished it clearly understood that by pyæmia he meant only that form of blood-poisoning accompanied by the so-called *metastatic* abscesses; for he considered *septicæmia* to be an entirely different affection.

In examining the class of patients who have this disease, it will be seen that they are those whose blood tends to form a weak clot. Any depressing cause,—too frequently present in such cases,—such as improper food, bad air, etc., and, above all, hemorrhage, will produce a state of hypinosis, so that the blood forms a soft, *friable* clot. The occurrence of pyæmia in such cases has been explained by the readiness with which absorption takes place when the vascular system is comparatively empty. This is undoubtedly true with regard to *septicæmia*, but not with regard to *pyæmia*.

When we consider the interference with function, and consequent retention of excrementitious matters, resulting from extensive infarction of the lungs, liver, kidneys, etc., it seemed to Dr. N. that there was no occasion to go outside of the economy for a septic blood-infection. We constantly have a typhoid condition, resulting in death, when any one organ, such as the kidney, is chronically incompetent to perform its functions: how much more likely is this to obtain when not one but *several* organs are involved, and that so suddenly as not to permit a vicarious action to restore the balance! indeed, in many cases the organs usually vicarious to each other are involved in the infarction.

If the view that he had enunciated some six months ago was correct, we can thus readily explain some of those otherwise almost inexplicable cases of pyæmia where there is no wound, or its occurrence some time after a wound has soundly healed. Thus, let a fall produce an injury of any of the more superficial veins, such as a rupture of the internal coat, and of course a thrombus will form. This clot in the vein sets up an inflammation in the surrounding tissues, the inflammatory products of which being absorbed, the clot extends into some larger vessel, portions are swept away in the blood-current, and we have pyæmia from the embolism of the various organs causing an *auto-infection*, if I may so term it, from non-elimination of excrementitious substances.

Dr. Nancrede thought it a great pity that the study of pathology usually ended wtih placing a section of the diseased organ under the microscope and merely trusting to the most obvious interpretation of the appearances observed. He thought that we should look at the physiology in connection with the microscopic appearances of a diseased organ.

Dr. GUITÉRAS said the embolus did not have to follow any devious track, but went directly from the right heart through the pulmonary artery. In all cases of croupous pneumonia it is well known that there is a tendency to clot in the heart, and directly from this a fragment may be shot off and lodged in the lungs. Outside of this question he did not believe that this (case) had anything to do with pyæmia. It is well known that emboli are divided by all writers on the subject into *two* classes, specific and mechanical. The specific carry some special poisons or irritant properties through the action of which the pyæmic abscess is produced. But this has been a simple mechanical embolus, such as we find in heart disease, producing congestion and rupture of the blood-vessels beyond it,—hemorrhagic infarction. In this case the infarction was followed by gangrene, which, though rare, is more common to the mechanical than to the specific emboli.

Dr. NANCREDE said he had misunderstood Dr. Guitéras as to the source of the embolus, and, therefore, of course the first part of his remarks did not apply to the present case. He likewise was anxious to know on what authority the division into mechanical and infectious was made,—what grounds there were for believing there was a different cause producing these differing effects; as, unless proved by absolute demonstration, he thought we had no right to assume a specific cause.

If we examine the clot in a case of this kind, and one in pyæmia, he thought an explanation could be found without calling in the aid of any specific infection. In the present case we have a firm, hard, perfectly healthy mass of fibrin, not containing many cells proportionally, while in the pyæmic one we have a soft, friable, largely corpuscular clot, loaded with broken-down detritus, and eminently fitted to set up inflammatory trouble.

Dr. GUITÉRAS said, further, that in the specific embolism the breaking-down of the lung assumes the spherical shape characteristic of abscess, and the mechanical is wedge-shaped, with the base towards the pleura. He referred Dr. Nancrede to Cohnheim's admirable exposition of the subject, found in vol. v. of Ziemssen's Cyclopædia of Practical Medicine. If further proof were needed, he called attention to the fact of this being but one infarctus, as contrasted with the plurality of metastatic abscesses.

(To be continued.)

REVIEWS AND BOOK NOTICES.

YELLOW FEVER AND MALARIAL DISEASES: Embracing a History of the Epidemics of Yellow Fever in Texas; New Views on its Diagnosis, Treatment, Propagation, and Control. By GREENSVILLE DOWELL, M.D., Professor of Surgery in Texas Medical College, etc., etc. Philadelphia, Medical Publication Office, 115 South Seventh Street, 1876.

This volume of 241 pages, written from personal experience, which, according to the author's statement, "is now equal if not superior to any one living in the United States, as I have treated over two thousand cases in hospitals and private practice," is intended, in part at least, to correct false impressions, current in our text-books, and compilations now in course of publication. Prof. Dowell claims that his observations prove—1. That there are no permanent or universal pathological lesions in yellow fever. 2. That the adjective yellow is not appropriate, because not more than one in six of the patients affected become yellow, and of those who die of black vomit not more than one in three turns yellow before or after death. 3. The yellowness of the skin, when it does occur, is not due to bile, but to the hæmatin of the blood exuded into the intercellular spaces. 4. That dengue is much like a mild case of yellow fever, but it never kills, treat it as you will; while yellow fever is very fatal, treat it as you may. 5. No one ever has a second attack of either dengue or yellow fever.

This work is evidently the production of an earnest and devoted physician, who has enjoyed unusual opportunities for investigation, and it is therefore eminently worthy of careful study. Its unquestionable value is, however, somewhat diminished by a want of completeness of observation, of moderation in statement, and of rigorous exactitude in deduction, —blemishes which we trust will be corrected in a future edition, when that is called for at the hands of its accomplished author.

J. G. R.

OPHTHALMIC AND OTIC MEMORANDA. By D. B. ST. JOHN ROOSA, M.D., Professor of Ophthalmology and Otology in the University of the City of New York, etc., and EDWARD T. ELY, M.D., Assistant to the Chair of Ophthalmology and Otology, etc. New York, William Wood & Co.

For the hard-worked student and general practitioner this little book may prove of value as a handy work of reference on the anatomy, therapeutics, and surgery of the eye and ear. We cannot conceive of its being of any service to the well-posted specialist. We do not think that anything of much practical use can be taught, in a manual of this size, on such subjects as refraction, accommodation, and the ophthalmoscope. For the compass of the book, too much attention has been paid to anatomy. It is neat in typography and general appearance, and small enough to be readily carried in the pocket.

NUTRITION IN HEALTH AND DISEASE: A CONTRIBUTION TO HYGIENE AND TO CLINICAL MEDICINE. By JAMES HENRY BENNET, M.D. Second Edition, octavo, pp. 248. Philadelphia, Lindsay & Blakiston, 1876.

Dr. Bennet's object in writing the present volume was, as he tells us in the preface to the first edition, here reprinted, to draw attention to the fact that the imperfect performance of the digestive and nutritive functions leads slowly but surely to ill health, to disease, and to death.

The opening chapters are devoted to a consideration of digestion and nutrition in health, food, the nutritive requirements of man considered with reference to social occupations, to temperature, and to climate. A chapter is then devoted to nutrition in animals and plants, after which the author considers defective nutrition, the relation of urinary deposits to digestion and nutrition, and the book winds up with practical deductions as to the food-requirements in health, individual peculiarities, food-requirements in ill health, and confirmed dyspepsia.

The style of Dr. Bennet's book is pleasant, not severely logical, a little inclined to be gossipy,—in fact, the sort of book which is "written in hours of relaxation." The ground which it covers has for the most part been pretty thoroughly gone over of late by writers like Pavy and Edward Smith, and we consequently find little that is new in the present volume.

The first edition of Dr. Bennet's book was published eighteen years ago, and was exhausted within a twelvemonth of its appearance. Various engagements have since prevented the publication of this second edition, which the author especially dedicates to the readers of his various works, "a benevolent, sympathetic auditory scattered over the world." To this auditory the volume may safely be left. The cold critical reader will probably find more recent and, perhaps we may say, less discursive and more scientific works rather better suited to his wants.

WALSH'S PHYSICIAN'S COMBINED CALL-BOOK AND TABLET. Second Edition. J. B. Lippincott & Co., Philadelphia.

A very good book of its kind, containing some novel features, prominently among which we commend the interleaving of the diary for note-taking, memorandum-making, etc. It is so arranged that the fiscal year may be commenced at any time, and accounts may be kept quarterly or in blocks or masses not agreeing with the calendar year. The secret of its popularity in the past is easily guessed.

GLEANINGS FROM EXCHANGES.

THE BLOODLESS OPERATION (*The British Medical Journal*, January 30, 1876).—That the use of Esmarch's bandage is not contra-indicated by the presence of profuse suppuration in severe injuries, appears to be proved by the following case.

M. B., aged 60, was admitted into the Queenstown Hospital, suffering from a compound and comminuted fracture of the tibia and fibula of the right leg. With a view to conservative surgery, an attempt was made to save the limb; but, after a fair trial of splints, including McIntyre's, extensive suppuration occurring, it was deemed necessary to amputate.

It may be mentioned that on the patient being admitted to the hospital the upper fragment of the tibia was found to protrude through the wound, and had to be sawn off. Owing to the man's restlessness, however, it was impossible to bring the fragments into perfect apposition and retain them; besides which, profuse suppuration and the attendant irritative fever threatened a fatal termination unless the offending cause was removed. The operation was performed under chloroform. The leg was removed by the circular method above the knee. Little blood was lost during the few minutes of the operation; and at the date of this report the stump has nearly healed, being treated antiseptically from the first. It is, however, to the careful application of Esmarch's bandage that the success of the case is chiefly owing; and, although there was extensive purulent infiltration at the time the elastic bandage and tubing were applied, there have been not only no ill effects in the stump since, but not even one bad constitutional symptom. This is due chiefly to the absence of hemorrhage, which in ordinary amputations is so common a cause of death, and which can be easily avoided by the employment of this most excellent bandage.

TEMPORARY INSANITY AFTER CHLOROFORM.—Mr. John Ewens sends the following communication to the *British Medical Journal*, January 6, 1877: The interesting report of a case of "profound intoxication following anæsthesia by ether" in the *Journal* of December 30 reminds me of, I believe, an unusual case, which occurred in my practice about eight years since, of temporary insanity following the inhalation of chloroform. A woman had undergone the operation of removal of a cancerous tumor under the full influence of chloroform. On recovering consciousness, she manifested an intense aversion to myself, who had operated, so that it was absolutely necessary for me to leave the application of sutures, bandage, etc., to the surgeons who had assisted me. Meanwhile she was constantly muttering to them her desire that they should "kill" me. This condition had entirely passed off by the time of my next visit on the following day, and she had no recollection of the circumstance. She had previously expressed her determination that no one but myself should perform the operation: so there was no dislike of me.

In the other case the operation is stated to have been tedious, and the quantity inhaled necessarily large. Doubtless, as with alcohol, the first effect of ether is as a stimulant, and then larger doses act as a depressant, thus giving it a similarity of action to chloroform; and thus the question may be raised, how far ether is superior to chloroform in protracted operations. But the point to which I wish to call attention is the intoxicating effect of chloroform in my case. It may be more common than I am aware of, but I have never read of a similar case. I think it an excellent plan to administer a good dose of brandy-and-water before the inhalation of chloroform, thus giving a stimulus to the heart's action, and guarding it against the depressing effect of the anæsthesia. In a case of an old woman aged 87, whose finger I removed about three years since, it acted remarkably well, appearing to assist the anæsthetic action of the chloroform.

FAILURE OF SALICYLIC ACID AND SALICIN IN RHEUMATISM.—The *Lancet*, November 11, contains a report by Dr. Tuckwell of two cases of rheumatic fever which were treated with full doses of salicylic acid. In both the immediate effect of the acid upon the rheumatic symptoms was remarkable; a rapid falling of the temperature and pulse-frequency, a speedy subsidence of pain and swelling of the joints, a cleansing of the foul tongue, and arrest of the sweating, being observed. But in both alike, together with the satisfactory abatement of these symptoms, there came on a set of other symptoms which may thus be summarized:—humming and buzzing in the ears with gradually increasing deafness; a peculiarly loud, deep, and sighing respiration; a strange restlessness gradually increasing to delirium, not unlike that of delirium tremens, with involuntary evacuation of urine and fæces in the worst of the two cases; a slow and laboring pulse; an olive-green color of the urine. All these symptoms declared themselves at the same time that a low temperature, a slow pulse, and an absence of all rheumatic appearances showed that the disease itself was in abeyance. No sooner was the medicine withheld than the strange symptoms ceased and the rheumatism returned. The medicine was administered at first in the dose of one scruple dissolved in three drachms of the solution of citrate of ammonium given every three hours. This was gradually reduced, on the appearance of toxic symptoms, to ten grains, thrice daily, but was not tolerated even in this dose.

In the same number of the *Lancet* a case occurring under care of Dr. Green is reported,

in which salicin was employed in acute rheumatism. The salicin was given early, and pushed as far as the patient could tolerate it. He frequently had headache, and twice complained of dizziness and noises in his ears. He vomited on three separate occasions. The salicin did not notably lower the temperature. It did not control the pain, opiates and chloral being required. It did not prevent the occurrence of endocarditis, pericarditis, or pleurisy. It is, however, worthy of note that the perspiration, which was acrid for a day or two, became afterwards slight and unirritating, so that no miliaria appeared.

WANDERING LIVER.—Prof. Chvostek (*Allg. Med. Zeit.*, November 23, 1876) has observed the following case. Only seven similar ones are on record. The patient was a woman 53 years of age, had been married eighteen years, and had given birth to twelve children, nine of whom were still living. After each delivery the lochial discharge continued for six or eight weeks, the abdominal walls were much relaxed, and the bowels very constipated. In 1869, cramps came on, and, after (in 1870) lasting for three months in an aggravated form, completely disappeared until, in 1874, they again returned. In February, 1875, medical advice was resorted to. Colicky pains were then complained of, which, proceeding from the neighborhood of the stomach, became particularly severe around the region of the navel. They lasted for an hour every day, were not alleviated by morphia, prussic acid, etc., and so completely deprived the patient of her sleep and appetite that in the latter part of the summer she was, in consequence of her weak state, obliged to keep to her bed. Her medical adviser administered narcotics and laxatives; and by this means, and through the removal of a large quantity of fecal accumulation, relief was at last obtained. At another time there was vomiting of a dark-colored fluid, which (in connection with the cachexia present, and the existence of slight jaundice and a hard abdominal tumor) led to the supposition that it was a case of carcinoma of the liver. The abdominal walls were everywhere relaxed, and covered with large meandering veins; whilst strong peristaltic movements of the bowels could be also observed, especially during the attacks of colic.

On examination of the tumor by Prof. Chvostek, a distinct notch could be felt beneath its lower border and above Poupart's ligament. On the other hand, percussion of the natural region of the liver gave a perfectly clear sound; and this clear sound, be it particularly observed, was not only evident in front, but behind also. The spleen was in its proper position, and of normal size; and there was no displacement of any of the other viscera. The tumor was freely movable; it settled down in the upright posture of the patient; but by elevating the pelvis it could (although not without giving much pain) be replaced in its normal situation, when the dulness or percussion natural to the region of the liver at once returned.

We know very little about the etiology of this affection. But the author of the paper thinks the view taken by Meissner a very plausible one,—namely, that as pendulous belly, pregnancy, etc., are of frequent occurrence, while this dislocation of the liver, on the contrary, very seldom happens, such dislocation may arise from a congenital laxity of the suspensory and coronary ligaments, which give way and so allow the liver to fall out of its natural position. The relaxed state of the abdominal walls, arising from repeated pregnancies, also contributes to, or aggravates, the evil; for five of the eight cases occurred in women who were all more than fifty years of age.

The *treatment* of this dislocation is obviously to replace the liver in its natural position and to endeavor to keep it there. Elastic bands or rollers are not suitable for the purpose, while a compress applied beneath the liver cannot be borne by the patient. Prof. Chvostek, therefore, thinks that we should in such cases contrive a bandage for the middle and lower part of the abdomen, by which the upper part of that region would not be too much constricted, and the consistence of which should be nearly equal to that of a truss.—*Medical Press and Circular.*

ON TREMBLING IN PARKINSON'S DISEASE (PARALYSIS AGITANS).—We extract the following from a translation of a recent lecture by Charcot in the *St. Louis Medical Record.*

M. Charcot began by showing that the term "*paralysis agitans*" is not appropriate. In fact, it is paradoxical to give the name of "paralysis" to an affection in which the muscular strength is preserved intact for long periods. Further, the word alarms the patient, leading him to imagine he is suffering from some grave organic lesion, while in reality no one has ever discovered any serious or constant alteration up to this time, although the most careful microscopical examinations have been made. The qualificative "agitans" added to the term paralysis is inexact as well, at least when applied to certain forms, in which, although they are well marked, trembling may be wanting. These considerations have led M. Charcot to propose calling this affection *Parkinson's disease*, after the name of the English physician who in 1817 first called attention to this affection.

To M. Charcot belongs the merit of having clearly separated paralysis agitans from another very interesting affection, *insular sclerosis*. According to M. Charcot, in Parkinson's disease the trembling most commonly begins in one of the limbs and becomes generalized gradually, "always, however, respecting the head." In drawing attention to two cases of paralysis agitans he compares the disease with insular sclerosis as follows: "You will

observe that in these patients the head does not participate in the trembling, or, if it appears to be shaken by the oscillations, that the latter are evidently communicated to it: there is a transmission of the shakings of which the body and limbs are the seat." M. Charcot compares this phenomenon of transmission to that of the equestrian who submits to the movements which are communicated to him from his steed. If the patient's limbs and body are kept fixed, the head does not tremble. Trembling, in fact, is not, according to M. Charcot, an inevitable accompaniment of Parkinson's disease. There is, indeed, a variety in which the trembling is so slight that it is not noticed by the patient, or it appears only after three or four years, or it may be wanting throughout the whole course of the affection.

M. Charcot continues his lecture by the citation of various cases, and concludes as follows:

First, the trembling of the head, which is sometimes seen in Parkinson's disease, is a transmitted trembling, differing thus from that which occurs in insular sclerosis.

Second, there exists a form of this disease in which trembling does not make its appearance, or, at least, does not manifest itself until late, after the disease has been fully established for years.

Salicylic Acid in Acute Rheumatism (*Brit. Med. Jour.*, December 30, 1876).—J. B. had been suffering from subacute rheumatism for a week, and was under alkaline treatment. He derived little benefit during this time, and the rheumatism somewhat suddenly assumed the acute form and seized upon all the large articulations. The affected joints were much swollen, very tender, and red; all voluntary movement was gone, and there was lancinating pain in the left groin and the back. There was nearly total suppression of urine, with anxious countenance, hurried breathing, a hacking cough, headache, and "pain at the heart." The pulse was intermittent and rapid. There was no murmur on auscultation, but the normal cardiac rhythm was replaced by five or six "hurried beats," followed by a distinct pause, and then repeated.

The patient was placed between blankets, the affected joints swathed in cotton-wool, a linseed-meal poultice applied over the heart, and the following prescription ordered: R— acidi salicylici gr. 80; liquoris ammoniæ citratis ℥ij; potassii iodidi gr. xv; infusi aurantii ad ℥viij. An ounce to be taken every two hours. The medicine was begun at 2 P.M., and at 6 P.M., after the administration of twenty grains of salicylic acid, the patient's friends noticed "a change." At 8 P.M. he was visited, and found perspiring profusely, quite rational, and feeling easier. The pulse was still irregular. The medicine was ordered to be given every hour during the night. Strong beef-tea, with a tablespoonful of brandy every two hours, had been given *ad libitum* from two o'clock, and was ordered to be continued in the night. Fifteen hours afterwards he was again visited, and found moving his arms and legs quite freely, declaring himself "painless," and the only visible trace of the rheumatism was a faint blush on the left inner ankle. He had been sleepless and wandered a good deal during the night, wanting to get out of bed when the pain left the joints. The pulse was still intermittent, but the heart's action was less tumultuous, and there was very little præcordial pain. He was ordered to be well rubbed with a dry, warm blanket, care being taken to avoid exposure. A purgative of calomel and jalap was administered, and the medicine ordered to be given every *four* hours. The brandy was stopped and beef-tea continued. Cold to the head could not be borne, as it produced a general chill and made the patient feel uncomfortable.

From this time—*i.e.*, twenty-one hours after the administration of the salicylic acid, during which time he had one hundred and seventy grains of the drug—there was no relapse of the rheumatism. The excitement, however, remained while the drug was continued; and, in spite of chloral and Battley's solution (ten grains of each every three hours), the sleeplessness persisted until its entire discontinuance twenty-four hours later. So delirious was he for two nights succeeding the disappearance of the rheumatism that he was kept with difficulty in bed, and even struggled with those near him. The second night after the discontinuance of the acid, the patient slept soundly without a draught. By this time the secretions were restored, and he was allowed to sit by the bedroom-fire and have a liberal diet.

New Method of Treating Urethral Strictures (*The Medical Record*, January 13, 1877).—At the meeting of the Académie de Médecine at Paris on November 7, 1876, M. C. Fort described a method of treating urethral strictures of small calibre, which he has employed for seven years with great success. He first passes a filiform bougie through the stricture and leaves it in position for twenty-four hours. The presence of the bougie excites a slight inflammation of the tissues that form the stricture, which softens them and renders them more extensible. The bougie is provided with a metallic cap, to which catheters of various sizes may be attached. At the end of twenty-four hours a conical catheter, three millimetres in diameter at the largest part, is attached to the bougie and pushed forward through the stricture, the guide keeping it in the proper direction. The catheter is then withdrawn until the metallic cap on the end of the bougie emerges from the meatus. The catheter is now detached from the bougie and replaced by another, which is five millimetres in diameter at its largest part. This is in turn made to traverse the stricture, then withdrawn, and replaced by a third catheter which

measures seven millimetres in its largest diameter. The bougie during the passage of the catheters coils up in the bladder, where it can do no harm.

By this method even very tight and indurated strictures may be completely dilated at a single sitting. The guide removes all danger of making a false passage. The pain is so slight that anæsthesia is unnecessary. The operation rarely causes any hemorrhage.

MISCELLANY.

SCURVY IN THE ENGLISH ARCTIC EXPEDITION.—It would appear that the cause of the outbreak of scurvy in the sledging-parties of the English Arctic Expedition was, as hinted in our London letter in No. 239, January 20, undoubtedly due to disregard of the positive instructions issued. The directions of Sir William Armstrong were detailed and explicit. He further gave them a work on scurvy. Sir George Nares took upon himself to make out the sledge dietaries without lime-juice. To the remonstrances of Dr. Colam he replied that if he included lime-juice he must omit more important matters. Commander Markham has testified that the few pint bottles taken were not carried as a specific against scurvy, but as a pleasant drink when the weather got warmer. Even now, Commander Markham does not consider lime-juice a specific for scurvy, and says that in future expeditions he would still go without it; but Nares and Stephenson think differently.

To *prevent clouding of mirrors* used in laryngoscopy, brush them over lightly with a little glycerin.

NOTES AND QUERIES.

WASHINGTON, D.C., February 20, 1877.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR SIR,—Permit me to call your attention to the following correspondence, and to request that it may be published in your journal.

Very respectfully and truly yours,
J. S. BILLINGS,
Surgeon U.S. Army.

[COPY.]

CAMP STAMBAUGH, WY. TER.,
February 7, 1877.

SURGEON-GENERAL U.S. ARMY, WASHINGTON, D.C.:

SIR,—I have the honor to inclose herewith, for the information of the Surgeon-General U.S.A., a communication received by me on the 6th inst.

Very respectfully, your obedient servant,
(Signed) CHARLES H. DODGE,
Hospital Steward, U.S. Army.

[COPY.]

BUFFALO, N.Y., January, 1877.

SIR,—Do you want a medical diploma? Some hospital stewards have obtained diplomas through our agency, and are practising successfully. Many are well qualified, but lack diplomas. The agent, having been a hospital steward during the late war, knows whereof he writes. Fully one-fourth of the physicians in the United States have procured their diplomas through our influence.

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Yours truly,
JOS. P. DONNER.

Address 580 LOUISIANA ST.,
BUFFALO, N.Y.

FORT RANDALL, DAKOTA,
February 15, 1877.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

In your issue of the 3d instant, under the head of "Translations," there is a brief paragraph to which I desire to call the special attention of the profession. It is upon the subject of "Injections of Hot Water in Uterine Hemorrhage."

During the past month, without remembering, if I ever knew, that Dr. Lidell, and perhaps others, had recommended hot water as a means of checking certain forms of hemorrhage, I used the remedy in the case of an incised wound, and was astonished at its rapid and complete success. I have used it twice within the past two weeks in similar wounds, and with equal success. It seems to me to possess all the advantages of the liquor ferri persulphatis, without any of the disadvantages of that drug.

It occurred to me at once that hot water might with advantage supersede all other remedies in uterine hemorrhage, and I resolved to give it a trial; but, before an opportunity offered, the translation referred to, page 203, attracted my notice. The delusion of the remedy being a new and untried one being now dispelled, but without in the least dispelling my faith in its efficacy, I desire to bespeak a fair trial of its merits by the profession generally.

S. S. TURNER,
A. A. Surgeon, U.S.A.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM FEBRUARY 11, 1877, TO FEBRUARY 24, 1877, INCLUSIVE.

BEDAL, S. S., ASSISTANT-SURGEON.—Dismissed the service. G.C. M. O. 18, A. G. O., February 10, 1877.

GARDNER, E. F., ASSISTANT-SURGEON.—To report to the Commanding General, Department of Dakota, for assignment to duty. S. O. 41, A. G. O., February 23, 1877.

SHUFELDT, R. W., ASSISTANT-SURGEON.—To report to Commanding General, Department of the Platte, for assignment to duty. S. O. 41, c. s., A. G. O.

PERLEY, H. O., ASSISTANT-SURGEON.—To report to Commanding General, Department of Dakota, for assignment to duty. S. O. 41, c. s., A. G. O.

COOPER, GEO. E., ASSISTANT MEDICAL PURVEYOR.—Relieved from duty in Department of California, and to relieve Surgeon Robert Murray of the charge of the Medical Purveying Depot in San Francisco, Cal. S. O. 40, A. G. O., February 21, 1877.

JAQUETT, G. P., ASSISTANT-SURGEON.—Granted leave of absence for one month, on surgeon's certificate of disability. S. O. 34, Department of the South, February 15, 1877.

GARDNER, W. H., ASSISTANT-SURGEON.—Assigned to duty at Greenville, S.C. S. O. 36, Department of the South, February 17, 1877.

BUCHANAN, W. F., ASSISTANT-SURGEON.—Assigned to duty at Morganton, N.C. S. O. 38, Department of the South, February 20, 1877.

COMEGYS, E. T., ASSISTANT-SURGEON.—To rejoin his proper station at San Felipe, Texas. S. O. 26, Department of Texas, February 8, 1877.

BUELL, J. W., ASSISTANT-SURGEON.—Assigned to duty at Fort Concho, Texas. S. O. 23, Department of Texas, February 5, 1877.

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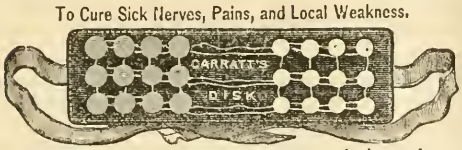

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